COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

TRANSCRIPT OF MEETING

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The foregoing meeting was held, pursuant to notice, on Thursday, January 22, 2015, beginning at the hour of 10:00 a.m., in Room 125, Capitol Annex, Frankfort, Franklin County, Kentucky, 40601, Elizabeth Partin presiding.

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CHAIR PARTIN: Let's get started. We do have a quorum today. So I will call the meeting to order. And the first order of business is approval of the minutes.

First order of business is approval of the minutes. And we have minutes to approve from the last meeting and from the meeting before that. So would somebody like to make a motion?

DR. NEEL: I move the minutes be approved.

MR. WHALEY: I will second.

CHAIR PARTIN: All in favor say aye.

GROUP: Aye.

CHAIR PARTIN: Any opposed?

Moving right along to old business. At the last meeting we were informed by Passport that they were going to extend the enhanced payments of primary care providers that had been given under the federal program.

And I would like to also give kudos to Passport because they just recently told me that they are going to include APRNs who are independent practicing in those payments. So that was really good news for those people who are trying to provide primary care in the state.

Along those lines, I would like to ask if any

of the other MCOs have decided to also include or continue with the enhanced payment system. The last meeting you all were going to think about it.

So could we hear from some of the others? Coventry?

DR. NEEL: We have three spaces down there for them. If we are going to have other questions, maybe have somebody come up?

CHAIR PARTIN: It might be easier to do that, just to have a representative sit at the table here so that you don't have to keep on getting up to the front table.

DR. NEEL: Don't everybody jump up at once.

CHAIR PARTIN: Thank you, everybody. So to the question, has anybody, any other organizations, besides Passport, decided to continue the enhanced payment program to primary care providers?

ANTHEM REPRESENTATIVE: I'll try to take that. Anthem. And we have decided not to continue the enhanced payment. Instead we are looking at other options associated with medical home concept and how we can incentivize our medical home concept.

MS. RICHARDSON: Kimberly Richardson with

Coventry. And we are continuing to look on the question. I'm sorry, your question was?

CHAIR PARTIN: Are you still thinking about it or is that a no?

MS. RICHARDSON: We are looking at our options.

CHAIR PARTIN: So it is a no and exploring other options?

MS. RICHARDSON: Yes.

CHAIR PARTIN: Yes.

MS. RANDALL: Good morning. Rebecca Randall with WellCare. Right now we are still evaluating the possibility. We are also examining potential avenues in our quality program. As we presented it to the committee at the last meeting, we have a pretty extensive pay for fee program that we are looking at currently. So we are looking at also how we can incorporate that into that.

CHAIR PARTIN: Thank you. And WellCare?

MS. HALL: I am Kim Hall with Humana Caresource. And we are reviewing our contracts. And we do direct to the prevailing Kentucky Medicaid rates. And they did go on and publish a few months ago a new enhanced rate. And we are looking at, if we can implement that, what our

alternative is.

CHAIR PARTIN: So you are still considering it?

MS. HALL: Yes. Because the last time I updated it in any form was when we were looking at the contracts. If any contracts had other terms, we just have to address every one all at once. But it has made it all the way through regulatory at least. And everyone is trying to determine if we go forward with everyone or we have to approach.

CHAIR PARTIN: All right. Well, thank you very much.

DR. NEEL: May I just make a little statement here? Because of the dire consequences of going back to the original Medicaid rates I can tell you that primary care practice is almost unsustainable at those rates. And obviously even the Supreme Court is understanding that because they are taking up the subject I believe as we speak because they realize that. And that's based upon the fact that Medicaid has to pay an adequate rate. Am I am correct on that, Lisa?

And so that's the discussion now is whether the rates, like in Kentucky, are adequate rates or

not. It really is dire because now if we don't have the enhanced rates, we are going back to the rates we had really before KenPAC, which was the per member per month that we had. And so that really makes for large Medicaid practices a decrease of almost 40 percent, not just 25 or 30 percent.

So I do not see how private practice will be able to continue at those rates. So I'm happy to see that some of the MCOs are at least considering it. But there is an alternative if we don't get that and that is to look at enhanced payments because of heinous measures and that sort of thing. And maybe we can replace it from that.

But I want everybody to know here that it is going to be dire as far as what's going to happen to network adequacy, access to care, and particularly access to quality care for the members in Kentucky.

And I know that the Medicaid Department cares about that. So I just wanted to make that little statement because we've really got to work on that.

COMMISSIONER LEE: I am Lisa Lee. And I am currently the Deputy Commissioner for the

Department of Medicaid Services. But beginning February 1, I have agreed to step into the roll of commissioner since Commissioner Kissner will be leaving. He will leave a void in the department and he will be missed, but we will carry on.

I would like to talk about the rate, reimbursement rates. The department has proposed incentive fees, which is not exactly what it is right now, but we have proposed some incentive fees for certain primary care procedures. And a list of those is on our website. If you haven't reviewed those yet you can do so.

That will only be applicable to the fee for service program. And we are currently awaiting CMS approval. But there are some codes that we hope to promote wellness that we are incentivizing those payments to.

MS. BRANHAM: So it is not necessarily procedures, it is --

MR. LEE: It is procedure codes. And they are listed on our website services, yes. Certain preventative services.

MS. BRANHAM: Okay.

CHAIR PARTIN: Well, we were going to congratulate you when it came to your turn here.

But you have stepped up. Welcome and congratulations.

We have new information about the work that is being done, a common forum, plus the MCOs for pre-authorization. And so that was an item on the agenda. But since we have got a memo update on that, it looks like the work group is moving ahead. And that's wonderful because I think that will be really helpful to providers if the work group can come together with a common form. They will make practice easier I think.

The next item, psych hospital and IOP denials, admission and readmission rates. At a previous meeting, I believe maybe two previous meetings, there had been a question put forth about information about those rates. And I was wondering if the department has done anything.

COMMISSIONER LEE: Yes. We have generated a report, but it has not been vetted through the department for accuracy. So we are still reviewing the report. And we hope to have it at the next MAC.

CHAIR PARTIN: Okay.

At the last meeting we talked about Anthem now providing a code for sports physical so that

patients can have a regular physical. And then if they need a sports physical subsequently in the year, that Anthem would also cover another physical for sports.

Have any of the other MCOs considered anything like that? It was, I think we left it at the last meeting that the other MCOs were thinking about something like that.

MS. RANDALL: We are currently evaluating the policy of adding this to our package. At this time we are looking at it.

CHAIR PARTIN: Okay.

DR. NEEL: Did she say they are?

MS. RANDALL: Yes, we are.

CHAIR PARTIN: Anybody else?

MS. SPENCER: This is Chrissy Spencer from Passport. We have always paid for sports physicals.

CHAIR PARTIN: In addition to the annual exam?

MS. SPENCER: Correct.

DR. NEEL: As a separate code? Or what code do you put on there?

MS. SPENCER: I believe we just use the regular well code. But we have no edits for

multiple visits.

DR. NEEL: At the last meeting, the commissioner admonished us to not commit fraud by making it a different diagnosis or something. And I understand that. But, on the other hand, we have all got to get on the same page because this is a big deal. There are a lot of us doing those. And we need to know. Are you going to come to a common -- you are just saying make it a well child and you are not editing more than one per year?

MS. SPENCER: That's correct. That's correct. But, I mean, if we wanted to use a different code, I think we would be okay with that too if it makes it easier for everybody to do it the same way.

COMMISSIONER LEE: I'm particularly happy if you don't deny it, if you use a different code. And I would just like to say that my concern is that if it is a well child visit, we do have to report to CHS on an annual basis a screening or a well child visit. If you are performing a sports visit when you are billing it as a well child visit, that is really going to skew our data and it will be over reporting.

And, in addition, we have that report broken

down at a county level. And we use that report to identify areas for outreach for children who may not be in -- counties that may have a low percentage of children receiving their well child check.

So I just want to make sure that any of those visits are not being reported in such a way that we would pick those up on a report to over-report the number of well child visits that are actually being taken.

MS. BRANHAM: Well, if you use the same code you can't distinguish. So there has to be a method for the prices so we are going to be able to delineate whether it is a sports physical or a well child visit.

So what's that proposal?

COMMISSIONER LEE: I think this is probably a topic that the MCOs and the department can talk about in our regular meetings with the MCOs.

MS. ANGELUCCI: Could that be the same thing? I don't know exactly what is the timeframe or expiration date. Couldn't, at the beginning of the school year, the child get the well care exam and a sports physical at the same time and kind of make it an all inclusive for that school year

whether they play or not?

CHAIR PARTIN: No. So people will come in and they will come in and get their school physical in July. And then they'll come in in January and say, oh, we decided to play sports.

MS. ANGELUCCI: Couldn't we make it a policy thing where they do it, just like when they get their -- at the beginning of registration just say we want to make sure everybody is well in case they want to play sports and let's just do it all and it happens all in the beginning of the school year. And everybody is well and they get checked whether they want to or not.

COMMISSIONER LEE: The department can continue to explore it and see what options are available and maybe we can speak again at the next MAC after we have some of our management meetings with the MCOs.

CHAIR PARTIN: It is a different exam.

MS. ANGELUCCI: I understand. I was thinking maybe there could be an all inclusive exam and we could cover all of our kids and make it less confusing.

DR. NEEL: Another couple of things that we need to consider is those of us out in the

trenches what we are seeing is this, is that the coaches are giving out the forms. The forms are changing. We have one for high school, one for middle school now and pre-school. We are probably going to have one for kindergarten. They keep changing things.

So Kentucky High School Athletic Association needs to be part of this discussion because the coaches are giving the forms out and telling the kids they can't practice until they get the forms. So they are ending up at urgent care centers, all kinds of wrong places, to get care. And that's part of my concern is that we are not really examining children. We are filling out forms.

And when we come to that, that's really a bad idea. And we have got to work on that somehow. So I will try to include them. And how long is it good for? In other words, is the one done in the spring good for football season or is one done in the fall good for tennis in the spring?

MR. WHALEY: I think you have a year.

DR. NEEL: Well, I know. But a lot of the schools aren't -- we are not all on the same page.

MR. WHALEY: And that's part of the problem.

MS. ANGELUCCI: Let's get on the same page.

CHAIR PARTIN: Okay. So the department is going to work with MCOs to come up with whatever coding we are supposed to use for those exams or forms or something.

COMMISSIONER LEE: We will continue to work with the MCOs on this issue.

DR. NEEL: Thanks, Lisa.

CHAIR PARTIN: Thank you very much.

Okay. It has been the procedure that the TAC would make recommendations to the MAC. And then the MAC would request that responses be in 30 days to whatever recommendations were approved. And the MAC subsequently then receives the response from DMS. But the TACs are not receiving the responses.

And so that was brought up at the last meeting. And I would like to ask that when the reports are or the responses for DMS are generated and provided to the MAC that they also be available to the TACs.

COMMISSIONER LEE: We will provide those responses within 30 days of receipt of those recommendations.

CHAIR PARTIN: Thank you.

COMMISSIONER LEE: Some of the recommendations, maybe if they need more detailed analysis, we would request an extension. I would notify you of that.

CHAIR PARTIN: Okay. Sure.

And then the last under old business is reimbursement. And Dr. Neel touched on that. I think we will be talking about that more and more.

Did you want to add anything?

DR. NEEL: No, not from that.

CHAIR PARTIN: Okay. So then next on the agenda are updates from the commissioner. And you are again welcome.

COMMISSIONER LEE: Thank you.

As you notice your binders are a little bit smaller. We are putting information on-line. You will have a link to the information. You can go to that. So I'm not going to go through the binder and read that to you.

There is one thing though that I would like to point out. And I believe that that is on your very last tab, the miscellaneous tab. The second document back, there is a memo from Commissioner Kissner to The Senate Chairman and the House Chairman interim. This is the LRC Report, the

Medicaid budget. You can see in the first quarter what has already been spent. I would just like you to take a look at that. It just gives you a good idea where the money in Medicaid is going.

And the document right after that is a State Fair Hearing Report. I'm not sure if this was a request from the MAC or not. But you can tell by looking at this report that the number of individuals requesting a state fair hearing is going down and it is being reduced.

And then the next document I think is the one that I really want to call your attention to, the MCO Medical Director Meeting Notes. This is from their November meeting. And I'm not going to go through it blow by blow. But I would like for you to sort of kind of look at these minutes and digest them.

And particularly I would like you to pay attention to Page 3 about halfway down the page. You can see that Dr. Caudill has been visiting some dental vans and I think, Dr. Riley, this may be of importance to you.

Some of the things that are reported here, of course, are a little bit concerning. And what I would ask of the MAC is that you, particularly Dr.

Riley, is that you review these notes. And we will be submitting an ordinary regulation.

Our dental regulation is going to be amended probably within the next month. We will post that. It will be open for public comment. And I think that would be a good time for this MAC to help make some recommendations to ensure that all of the services being provided to our children in any setting, that proper protocols are followed. Because I believe that the dental vans have a purpose. But I also want to make sure that proper protocols are being followed when delivering services to our children. And so this is a document that I really would like your assistance on.

DR. RILEY: We would be happy to do that. At each TAC meeting, there are at least five complaints about these mobile dental units and their service/dis-service to the Medicaid children. So we would be happy to work on that.

COMMISSIONER LEE: And I think that the public comment period with the regulations would be a good opportunity to submit additional comments to the department, particularly around those dental units. Maybe some of your

recommendations that we could implement to make sure they are following proper protocol. And so that's in the binder.

A couple of other things from the department.

We have released an RFP for a new MMIS. That is posted on Finance's website. If you desire to have any information about that, you can go to Finance's website and you can call the Finance. Because individuals in the department will not be able to answer any questions or talk to you about that procurement.

We did talk about the wellness incentive a little bit. And on January 30, the department is hosting a webinar in conjunction with the Department for Behavioral Health and the Office of the Inspector General. The webinar is geared towards the Behavioral Health Services Organization that may -- you may want to enroll in the department to deliver services under the PHSO Regulation.

In addition, we are going to be having four forums that are related to community based waiver rules that will be taking place. I do have some fliers. They did not make it into your binders. So if you are interested in those fliers, you can

pick up one of these fliers. And it will tell you the locations and a little bit more about those forums.

And I think that's all the updates I have. And I would be more than happy to answer any questions.

CHAIR PARTIN: As you've done today, I would like to ask that since we are going to receive the binder on-line, I didn't get home from work last night until almost 9:00 o'clock. And there it was. There was no way to read it.

So if there is anything pertinent that we need to see, even though it has been sent to us on-line, would you please include it in the smaller binder that we get and call it to our attention at the meeting?

COMMISSIONER LEE: Absolutely.

CHAIR PARTIN: Okay.

MS. ROARK: I would like to ask a question to the commissioner and MCOs that I wondered or heard there is a House Bill that was going to be passed that MCOs are going to be paying for rehab.

Is that true or false?

COMMISSIONER LEE: Did you have a House Bill Number or --

MS. ROARK: No. There is a group that went. And the Governor -- I seen a video on Facebook -- and they were talking about passing a House Bill to get more rehabs to help people that is dealing with heroin or whatever, substance abuse.

CHAIR PARTIN: Is it part of the heroin bill maybe?

MS. ROARK: Yes. So you have not heard?

COMMISSIONER LEE: I don't have any additional information on it right now.

MS. ROARK: Okay. Thank you.

CHAIR PARTIN: Any other questions for the commissioner?

DR. NEEL: Lisa, on the fees, the new rate schedules, I'm looking under fee and rate schedules here. And they are talking about fees starting January, 2014. Am I look at something old? Out patient laboratory fees as of January, 2014. Are those all correct? Are these old schedules I am looking at?

COMMISSIONER LEE: I would have to look at the website. If you want the information about the incentivized fees, I can send that to you in an email. It is on our website. I don't know exactly where it is on there right now. There

should be a link.

DR. NEEL: The website is pretty large.

COMMISSIONER LEE: It is. There should be a link or a document titled enhanced fees.

DR. NEEL: Okay. That's what I'm looking for. Okay. Thank you.

CHAIR PARTIN: Would you send us an email?

COMMISSIONER LEE: We will send that document to the MAC. And we are waiting on CMS approval on that.

DR. NEEL: And the MCOs are aware of all that and they will weigh in on that type of discussion, too, or not?

COMMISSIONER LEE: This is a fee for service only, a payment methodology. It is under what's new.

DR. NEEL: Under what's new?

COMMISSIONER LEE: Yes.

DR. NEEL: That's a great place for it.

COMMISSIONER LEE: And it is Medicaid preventative and wellness enhanced fee schedule.

DR. NEEL: I've got it. Thank you very much.

CHAIR PARTIN: Still send us the link, please.

Okay. Moving right along, we have reports

from the TACs. First up, behavioral health. Children's health. Consumer rights and client needs.

Dental.

DR. RILEY: The Dental TAC met in December, 2014. The minutes are in the binder. So I will just highlight the recommendations from the TAC.

The first one is that it has been reported to the TAC that one of the MCO dental sub-contractors is reporting dentists to the National Practitioner Data Bank when the dentist decides to no longer participate in the plan but they fail to notify the plan in writing.

And providers have not been made aware of this. Most of them who don't notify are too busy complying with the ever-increasing rules and regulations to write an additional letter. They just stop seeing the patients of the plan.

We feel that this use of the National Practitioner Data Bank is a bastardization of the intent of the bank. Failure to file paperwork has nothing to do with the clinical practices and actions of the provider.

The data bank is supposed to be a repository of claims and malpractice actions against

providers.

The TAC recommends that DMS have the plan cease and desist from these reports to the National Practitioner Data Bank. Terminating the provider from the plan and no longer processing his or her claims should be sufficient sanction for failure to submit paperwork.

And the second one is, it is the understanding of the TAC that the MCO dental subcontractors are required to, by contract, to have a Kentucky licensed dental director. This is not the case for each MCO plan. The TAC recommends that DMS review this contractual requirement and mandate any necessary changes.

In addition, the TAC requests that these state licensed dental directors participate in the quarterly TAC meetings as well as the monthly medical directors meeting.

CHAIR PARTIN: Thank you. Does anybody have any questions? Comments? No. Okay. Dr. Schuster just came in. So would you like to give the behavioral TAC report?

DR. SCHUSTER: I hate to make such an entrance. Thank you very much. And I apologize for being late.

The Behavioral Health TAC met on January 13. We had invited all five of the Medicaid MCOs and their behavioral health representatives. And they were all present.

In addition, we had five TAC members there, a great number of behavioral health providers, consumers, and family members. We also had staff from the Kentucky Department for Medicaid Services and a special thanks to Lynn Flynn for attending. That was very helpful. And representatives from the Governor's Budget Office.

We had invited The Kentucky Department for Behavioral Health and Intellectual Disabilities to send a representative, but no one was in attendance.

We requested that the MCOs answer these questions: Has your medical necessity changed in the past year? If so, how can the new one be accessed. How many behavioral health professionals outside of your community mental health centers were now credentialed. As you know, they have opened up a mental health network. What is their distribution across the state. Where can an individual go to see a list of the mental health professionals in the network.

What types of advisory groups do you currently have that a consumer, family member, or advocate members, and what committees need such membership? And what will be your goal and focus in the coming year for demonstrating increased integrated care for your members.

All of the MCOs discussed their medical necessity criteria with only Aetna, Coventry, and MHNet indicating that there was a significant change in theirs.

All of the MCOs gave direction to accessing the updated version of the criteria. Each of the MCO's reported on the number of mental health professionals outside of the CMHCs. Written information was provided for all, except for Anthem who will forward the information to me separately.

The range of professionals was from 570 with Humana Caresource to about 1600 with Aetna, Coventry and MHNet.

The most useful information was provided by Passport who broke down across the Medicaid regions the various types of mental health professionals. Each of the MCOs stated, as they have in the past, that they had consumers, family

members, and advocates serving in various advisory committees. However, consumer and family members who were in attendance at the meeting noted that the request for participation was frequently not followed up by significant response to the input provided. They felt that they were token representatives on these committees.

The appeal for the MCO's to provide the behavioral health TAC with specific requests for participation was again made. Further, a strong appeal was made for meaningful dialogue between the MCO personnel and advisory committee members about the nature of the committee, the role that the advisory member would play, and the information needed by the advisory member to be a participating member of the committee. The emphasis was on a mutual process.

There was again discussion about integrated care and the goals that each MCO had in this area going into 2015.

One of the things that was again discussed was the use of the peer support specialists who are available to help in that integration. But it is unclear -- it remains unclear how they get called into the process.

The MCOs are saying they will pay for them. But if nobody actually authorizes their use, then we simply don't have that service available.

The Brain Injury Alliance of Kentucky rep asks when the NBIs Medicaid waiver slots would be opened up. No one present knew the answer to that question.

The Children's Alliance rep updated the TAC on progress that had been made regarding the NCIC coding problems. DMS has met with the MCOs around this issue, as has the Children's Alliance members.

A concern was expressed by several attendees that it would create a significant burden on providers if they had to go back and rebill previously submitted claims because of a change in the codes.

The MCOs expressed concerns that they would be unable to know which claims were new and which were being rebilled. All present asked the DMS rep to take the issue back to the department to seek a solution which would create the least administrative burden on the providers.

We have a number of recommendations. And I submitted these in writing on a separate sheet

that you all should have as well. But the NCIC billing issue should be resolved quickly with a standardized implementation and with a minimum of administrative burden on providers.

Another recommendation, the data from the MCOs reported on the DMS dashboard be made available to the behavioral health TAC, specifically lengths of stays at psychiatric hospitals and crises stabilization units, the percentage denials for each behavioral health service, in-patient and out-patient readmissions to psychiatric hospitals and CSUs and heinous measures reported by each MCO of ambulatory follow-up post-discharge from acute level of care.

We further request that each be separated by children up to age 18 and adult.

We also recommended that the data being used by Dr. Langenfeld for addressing the, quote, super-utilizers, end quote, of the ER be stared with the behavioral health TAC as we understand that the vast majority of those super-utilizers have a behavioral health diagnosis as well as a physical health diagnosis.

We recommend that the DMS working behavioral health TAC and the MCOs to further discuss

appropriate reporting and measures for documenting integrated care and its outcome, recommend the enrollment numbers of members across the MCOs be shared with the behavioral health TAC. Recommend that a date certain be established for making the ABI waiver slots actionable and be communicated to the behavioral health TAC. And also to the Intellectual and Developmental Disabilities TAC.

And, finally, that all of the MCOs communicate with DMS and with the behavioral health TAC their policy with regard to access to Abilify, which is one of the most effective and also one of the most expensive psychotic medications. It will be available in generic form. That expected date is April 1.

And we expect to see -- we hope to see -- greater access to Abilify once it is in generic form and cost is not as much of an issue. Our question is, will prior authorization continue to be required for each member for whom it is prescribed.

Thank you for providing this forum and your patience in my tardiness.

CHAIR PARTIN: No problem. Thank you.

DR. SCHUSTER: Any questions that I might be

able to answer? I think you all also have recommendations that were made in November. But you didn't have --

CHAIR PARTIN: Yes. And we have a quorum and we will move to approve those today so we can get to that. Thanks.

DR. SCHUSTER: Thank you.

CHAIR PARTIN: Nursing home care. Home health?

MS. BRANHAM: Hi. I'm Sharon Branham. I am currently serving as the Interim Executive Director of the Kentucky Health Care Association as well as Chair of the Technical Advisory Council for Medicaid.

We had our meeting yesterday here to discuss any and all issues that relate to providing home health in Kentucky. I would like to focus on a couple of things yesterday that were brought to our attention. And I don't think we were totally aware of what's occurring.

And, commissioner, you also addressed that briefly when you said about something that wasn't included in our binders about scheduling for waiver.

But I guess my first thing I would like to

say is the TAC is the forum in which we are supposed work to bring our concerns to the MAC to be approved. And over the past probably five meetings, it seems that we don't have the appropriate staff from the department attending the TAC meetings that can answer the questions brought forward on our agenda.

So that is a concern for me as the chair. Our meetings are scheduled a year in advance. So -- and we have -- and we have not called off a meeting. So they are there and appropriate and everybody knows.

So it's a little difficult when we are bringing forward issues that we have, either with traditional Medicaid or with MCOs. And MCOs have been there as of, I don't know, two years, working on issues. But we seem to not be able to communicate well enough or have our questions answered from the department.

So that is something that we are making a recommendation that we have the appropriate staff there to answer any and all questions or at least get the information back to us at the appropriate next meeting.

Yesterday we had a presentation by Deloitte

about Medicaid waiver management. And I have had a phonecall with -- that was put together a couple of weeks ago in regards to the call to identify providers in Kentucky who provide waiver services and a call to have those folks enroll for some training that is going to be provided by Deloitte.

So I put the call out. Lots of people signed up. And the reason for this was that we were going to an on-line, on-line forms that are going to be accessed and available for everybody to see, and edit, and know all parties involved that are providing labor services, what is going to be, what is the plan of care and any adjustments that are made.

Yesterday, when the presentation by Deloitte began, I immediately had some questions because there was a slide that was put up about the life cycle of the application of a waiver patient. And when we got to the sixth domain it said; waiver case management, the waiver case management agency would contact a case or a case manager supervisor.

And that is something that we were not prepared to -- we were not prepared for. It is something that we have been talking about for a period of time with Commissioner Kissner,

Secretary Haynes and Commissioner Anderson.

So the folks from Deloitte were just prepared to indeed go through their presentation slides. And they couldn't answer any questions that I posed about case management agencies and who was the case management agencies going to be in Kentucky. And since there was a rally to have home health agencies who provide waiver services in Kentucky have their waiver supervisors trained, which I found out yesterday in the TAC meeting that it is 16 hours of training. And it is going to occur and a Monday and Tuesday or a Thursday and Friday. And there is supposed to be nine stations throughout Kentucky whereby you can go and receive this training.

That if the purpose of this is for independent case management, then when were case management agencies going to be identified in the state and when were they going to receive their training because this is supposed to go live on April 17.

No one could answer my question.

I did feel somewhat bad for the Deloitte ladies who were there to strictly go through this slide presentation. But I guess we were met

yesterday with the inability to ask questions as to how this waiver implementation was going to occur and was it something different.

One gentleman from the department was brought in. And I asked for a list of waiver or a list of case management agencies in Kentucky and were they signed up for training. He said there were 150 to 200 case management agencies in Kentucky and I can't personally name one.

So, what I said yesterday in the TAC meeting was, if agencies have identified who their waiver case manager individuals are and they requested one per agency and then we self-teach the other individuals within agencies that provide this waiver services, we are going to go and spend two days in training, yet we are not clear as to how this actual implementation is going to work because we see ourselves currently in the model of a waiver case manager.

But the terminology of waiver case manager and case management agency are two different things.

So this brought some concerns to me and the other members that were there. Mostly because we didn't know exactly what's going on. And I know

that we have talked previously about independent case management. But if this is going to go live and agencies are going to access this information and it is going to be on-line, then they are going to have to have -- it says that additional documents to substantiate request for services would be uploaded to the client's electronic medical record.

If that's uploaded to the client's medical record, then every agency needs the ability to scan in PDF.

So I guess I come today saying that this is a change we were not prepared for. And we don't know how it is going to work. Part of the issue yesterday that was brought forth from agencies has been the number that you have to call to try to get patients qualified for the waiver services.

So now we are going to go on-line to do this, but we weren't told if we had to choose, if we have to be a waiver case management agency or if we are going to be a case supervisor or if we are going to be a provider of services.

And I did bring to the committee yesterday the problem that this is set up for failure. And that's not what we want. We hear on an ongoing

basis about the budget and expenditures of the budget in certain categories and lowering them. But this kind of bringing it to us without this dialogue of letting us know what is going to occur really is not the best way that we need to implement a new kind of program.

So the training, as we were told yesterday by Deloitte that they are going to do, is going to be set up in nine areas. And the training, like I said, they are 16 hours a day. But what is the training for? And nobody can answer that question other than how to enter data. But how do you get to be a case manager? How do you -- how do the case manager agencies? How do you sign up to be a case supervisor and how do you sign up to be a provider? Because that's not how it is currently -- the waiver is currently done in Kentucky.

Home health agencies are Medicare certified. And we provide the case management. We provide the services as well. This is almost like a dovetail or a part of the spa that was approved, the waiver that was approved through CMS to change the waiver services, but that kind of went dead in the water around October. And I didn't realize or

our association or home health agencies didn't realize that there was any movement on this until they asked if they could be a special guest and they presented this information to us.

So the home health TAC recommendation to the MAC is that we have some type of dialogue in relation to what is going to occur. Because the feelings yesterday were who is the case management agency? Because the verbiage was right there referring to case management supervisors. How are we going to know how that's going to occur?

If case management agencies -- and there is 150 to 200 in the state -- I would like to know who they are so that we can have a dialogue with them and we have the opportunity to make the decision if we are going to be a manager or a managing agency or a supervisor or a provider of services.

So I feel like we have a little bit of apples and a little bit of oranges in the cart that's up there. And the lead pony is in the back. So that's a recommendation that we need to have some dialogue very quickly because training starts February 2. And they don't have the schedule yet. Deloitte didn't have that to give it to us.

But I guess I felt like having a conversation, a conference call with them two weeks before to get, you know, agencies on board about this training. And then yesterday, you know, on this life cycle slide, I got to the sixth man and I'm, like, we are not going to play because we don't know how to do this.

So that's the first thing.

The second part of that at our meeting yesterday, we talked with the MCOs about long prior-authorization waits and prior-authorizations not coming to us in written form. And if we use any type of on-line form, whether it be faxing or submitting on-line through their portal, that that is still not a guarantee of getting your prior-authorization and phone calls can take I am told up to two hours to get a prior-authorization.

So we have this problem with prior-auths. And we have got this new way to do authorizations on-line. And we don't really know what we are to do to continue to provide this service for our recipients.

Again, it was requested by the MCOs to please contact agencies that are in their areas, at the liaison areas, about providing contracts. Because

some of the agencies have been a little bit slow in getting those contracts to sign up.

The second or the other thing is home health agencies received at the end of October a letter. That I thought it was fairly, you know, vanilla, I would say, about EPSDT benefit, Early and Periodic Screening, Diagnostic and Treatment Program.

And in this letter that came from Veronica Cecil, she's the Chief of Staff of the Division of Program Integrity and Medicaid, talks about if you only have an EPSDT Medicaid provider number, that provider number is going to be terminated June 30.

And I swear, I can't understand for the life of me how EPSDT services are going to be changing June 15 from this letter.

So we would respectfully request that a letter be put out to providers that clearly explains what we need to do with EPSDT patients before June 15 so we can start to make the transition for how we handle these patients.

And it is brought to our attention that home community based waiver recipients are receiving -- agencies are receiving letters that the pickle, Pickle Amendment, I've never heard of it, the Pickle Amendment, I guess, refers to something

that I haven't had the time to research because we just had our meeting yesterday. But I guess agencies are receiving letters that co-pays for their services were incorrectly calculated.

Therefore, agencies need to submit reimbursement to these particular patients that have been identified. And not all are identified. So it was brought to my attention that there is a couple there from 2008.

So what I was told yesterday was that, I guess the letter comes from Lee Guice. And then it informs them that they need -- that agencies need to send a letter to Sheila Davis who in turn sends it to someone else and they are working on these claims.

And they said that we didn't have to void the claims that were submitted with incorrect amounts of co-pay. But that the concern was brought if agencies paid the money to these individuals, is that going to affect them with the money in their account and reimbursement on a monthly basis to continue to qualify them for services. Is that clear? Do you understand? Okay.

Like patient A had a co-pay on a monthly basis and paid to the agency that was providing

the services. And now it has come to someone's attention that those co-pays were incorrectly calculated for a period of time. And the agency is being instructed to reimburse the patients the incorrect co-pay.

The concern is if agencies give these individuals the money, will that put money in their account that may not qualify them for services when they do the reevaluation on their financial things?

COMMISSIONER LEE: I wouldn't think it would be counted as an income because they qualified previously based on their amount that they had reported. So this is not -- it is more of a refund. I don't think it would be counted as income. But I will double check.

MS. BRANHAM: Well, could you provide to us, then, the correct steps if agencies are identified that they have been serving a patient for a number of years, because some of this can be substantial money, amounts of money that -- that they -- what are steps that agencies need to do. Because they are getting this letter, like, you know, send this back and you got to refund the money.

And if it could be put in a letter form to

us, then I would be happy to submit it to the home health agencies in the state so that they are not -- because I understand that not everything has been reviewed. So there are still several outstanding cases such as the ones that were brought to my attention this week.

So if I had a clear path to acknowledge on how to instruct the agencies on what to do, that would be very helpful.

And, lastly, you heard me talk about long wait times, the issues with waiver. And this brings me to let not only the MACs know, but the department know that something that we would really request that you do is look at presumptive eligibility for patients coming out of a hospital for services to be rendered.

Presumptive eligibility would assist the patient in getting services quicker in the appropriate delivery mode. So I think it is available in hospitals. It is available for pregnant women. So it is something that we are looking at how we can better provide care and get us off the phone and that we could have some type of presumptive eligibility.

And it has been shown in our surrounding

states that it also saves the department money. And it gets the patients in the appropriate providership.

So we would respectfully request that this be reviewed and have some feedback on this and let you know it is something we would like to work on. And there is conversation out there, in particular, fields that are going to be introduced around this.

If you have any questions, I will be happy to answer.

COMMISSIONER LEE: Will that be a part of the recommendation that you make?

MS. BRANHAM: Yes.

CHAIR PARTIN: Thank you, Sharon. Hospital? Pharmacy?

MR. SISCO: I am Scott Sisco. I'm the Director of Communications and Continuing Education for Kentucky Pharmacists Association.

We recently -- our board recently appointed the members of our pharmacy TAC that was reauthorized in the legislature last year. Those members are Jeff Arnold, who is long-term care pharmacist in northern Kentucky, Cindy Gray who is a 340B pharmacist with Diamond Pharmacy Services.

Christopher Betz, who is a hospital system pharmacist, Susie Francis works for Kroger as a community pharmacist, and Robert Warford who owns his own pharmacy.

So our board made sure that we ran the gamut as far as the different practice sites for pharmacy. We wanted to make sure everybody was represented.

In cooperation with the DMS staff, we have provided materials to all of the TAC members so that they can get oriented and come on board ready to work.

The first PTAC meeting has been set for Friday, February 20 at our office at 1222 -- sorry, I just found out I was going to do this this morning -- 1228 US 127 South here in Frankfort. It is up on the hill with McDonalds, KFC and all of that stuff.

Notification will be provided by DES staff on the CHFS website. And anyone is welcome to attend. And representatives from each MCO are strongly encouraged to participate.

Any questions?

CHAIR PARTIN: Thank you. Nursing TAC. I will give that report.

The nursing TAC met on January 16. And we only have one recommendation. And that is that the TAC has been informed that there are multiple cases where issuance of provider numbers with the Medicaid MCOs are delayed after the applications have been accepted. We have reasonable timeframes. One provider reported waiting since June, 2014 for a provider number.

And since that provider had been seeing patients in good faith anticipating the issuance of a number, a lot of those visits will be more than a year old. They won't be reimbursable.

So our recommendation is that DMS require the MCOs to issue provider numbers within 120 days of receiving the completed provider application.

And we think that is very generous. And we probably would like 30 or 60. But we are being very generous in asking that. And that's the only recommendation we have at this time.

Optometry?

DR. WATKINS: Yes.

We have plans to have our next TAC meeting in the near future. But our maintenance firm is still on the one comprehensive eye exam per provider per year which was a means to end in this

statute back last July. And we had brought it to the attention of the MCOs. And we are still seeing some denials on that.

We have not received a formal explanation from them on that whether they were going to acknowledge that and just wanted to get a response on if they had been able to find that on the website where that is now correct in the statutes.

MS. RANDALL: We did invite our vendor vision as they are here, we did go back and promise to look at the KAR and talk with our vision provider to ensure that they are administering the benefit appropriately.

At this time, we didn't find any discrepancies in the administration of that. But we would be a happy to take a look at specific examples. We are going back and provide them. If you have any questions regarding the administration of the vision benefit, I would ask you to direct it to Avesis here today.

CHAIR PARTIN: Thank you.

DR. BEDI: Good morning. I am Dr. Bedi. I'm the Chief Operations Officer for Avesis.

MS. LINTON: I am Dana Linton for Avesis.

DR. BEDI: So I would guess we would like to

start off just by answering that question and explaining the interpretation of benefits on how we read the KAR, which is the 907 KAR 1:632.

MS. LINTON: Avesis administers the benefit. The member receives one examination per year per member. However, additional routine exams are subject to prior-auth. We have never said that we will not reimburse that second exam. However, we just -- it is subject to prior-authorization based on medical necessity.

So any additional exams, we have the forms that are located on our website. The provider would just need to submit the prior-authorization form. That goes in our authorization management department for review. And at that time, upon overview for medical necessity, we would issue you an authorization and reimbursement for that second exam.

DR. BEDI: The way we interpret this is that if you have a child living in one county with one parent and the child needs to visit a parent in another county and they need services, that's an example of medical necessity and a need for another routine eye exam by another practitioner.

However, if that child has a challenge with

their eyewear and they have seen a practitioner, we would often -- the way I practice is that we would want that child to come back to that original practitioner for services.

Now, if there's a quality of care or a quality of service issue with the child or that member and there is a need to see another practitioner within the benefit cycle, well, that would be a prior auth and 99 percent of the time those are approved.

MS. LINTON: Correct. And there are exceptions to that policy. We have implemented guidelines for the children who are part of the foster care program. We have exempted the prior-authorization restrictions simply because of the living situation of those children.

DR. BEDI: Does that answer your question?

It's all about flexibility. It's all about that every child gets a pair of glasses so they can see well.

DR. WATKINS: Our concern is when they re-did the statutes back last July, though, it was put back into the regs that it reads that the person is allowed one exam per provider per year. And that is the way the regulation reads. So I mean

--

DR. BEDI: Well, that's the fee schedule connected to the KAR. If you look at Section 2 and Section 8, Section 8 is saying, no duplication of services, the department shall not reimburse for a service provided recently by more than one provider for any program in which the service is covered during the same time period.

So I think what you're referencing is the outside limit of care. And that's where the prior-authorization comes in. Section 2 within the KAR talks about medical necessity. So we based and designed our benefits based on medical necessity and the need of care.

So it is not saying no. But it makes absolutely no sense for a recipient to go to you, to me, to the next doctor and the next doctor and the next doctor, that's duplication of services.

DR. WATKINS: They may want a second opinion.

MS. LINTON: Then that would require a prior-authorization based on medical necessity. If they can provide reasoning for having that second look, then by all means we will look at that in the utilization department and issue a

prior-authorization for those services.

DR. BEDI: We have not gotten a lot of complaints or challenges from the provider network on this. As you know we administer multiple benefits, not always just routine benefits, with an exam and a pair of glasses. But we also provide services on all medical/surgical. So we would have optometrists, ophthalmologists, specialists and sub-specialists as a part of the network.

DR. WATKINS: How long does it take for you to supply the prior-authorization back?

MS. LINTON: We have a two day turnaround.

DR. WATKINS: So if this patient has already been seen? The patient comes in. You do the eye exam. You are filing for it and you have already seen this patient.

MS. LINTON: Well, it needs to be done in advance and we encourage that you check on it on-line. And you would be able to -- that that routine benefit was exhausted. Because once they have that routine examination, that will exhaust that member's benefit. If eligibility is being checked, then you would know upon arrival that that member has exhausted that benefit.

DR. WATKINS: So you are suggesting that when we make that appointment, that we ask to see what type of insurance that they have and that we go ahead and check their eligibility before they ever even arrive for that appointment and make sure whether or not they are going to be eligible for their exam?

DR. BEDI: Yes.

MS. LINTON: I would say that a lot of practices operate in that manner.

DR. BEDI: Then, again, there is two benefits. There is that routine benefit where you get that exam and the glasses. But if you break -- if you select an agent outside of the original practitioner, you needed to provide medical/surgical or secondary care for that patient, well, that's, you know, a different fee schedule. But it is still an administration of those benefits.

So there's two different benefits going on here. There's the routine eye care for glasses and then need there. And then there's all other eye care services that as an optometrist you are able to provide those services.

DR. WATKINS: Well, if they are there for a

medical reason and there is no need for a prior-authorization?

MS. LINTON: Correct. If a patient presents with a foreign body or something like that, by all means that doesn't require a prior-authorization. We are speaking to the routine examination benefit.

DR. BEDI: It is a little confusing because we are administering a routine benefit, which is the our benefit cycle. And then the full medical/surgical where there are no limits. I mean there are set determination limits and frequencies set forth within the state that we abide by and follow through the fee schedule.

DR. WATKINS: Right. Okay.

DR. BEDI: Thank you.

MS. LINTON: Thank you.

CHAIR PARTIN: Therapy services?

CHARLIE: My name is Charlie. I serve as a member on the therapy TAC. And I am speaking for Beth Ennis.

We had our most recent meeting on January 12. It was well-represented by the MCOs and we appreciate that.

We also have physical therapy, occupational

therapy, and speech therapy that are strongly represented by physical presence. We had submitted three questions to the MAC, two of which we have received responses from the Cabinet by email.

There is still one that remains. And it's surrounding the shift in EPSDT billing from the S. codes to CPT codes that is supposed to happen in June. And what we understand is that some providers have received a letter. But we have not actually seen the letter itself. But it doesn't fully explain the process and how a provider is expected to code that.

Specifically, do you use a provider type 45 and switch to the CPT codes? Or do you use a specific therapy code? So that still remains unanswered for us. And the other two have been resolved.

We also would like to know is there a specific start time for a change for EPSDT? Will it be July 1? Will it be June 15? And is it outlined in a letter to the provider?

CHAIR PARTIN: Okay. Thank you. Can somebody answer that now? Because it seems that that might be more urgent for people to know.

COMMISSIONER LEE: Regarding the EPSDT benefit, as you may know in the past the department had two provider numbers for many of their providers. For example, if a dentist was enrolled with the department and they were providing services under the EPSDT benefit, they provided the services that are listed in the same plan and on the fee schedule with their regular provider number.

If they provided any service outside of those services listed on our fee schedule, they used the EPSDT number. We felt that was barrier to care for many individuals. We eliminated the need for the second EPSDT number.

So now a provider can bill any service eligible for a child with their traditional Medicaid number.

We do have some transitions that we'll need to make for certain providers. And particularly now that some of the codes that were billed under EPSDTs, such as behavioral health services, are now covered under the state plan.

So we are going to be transitioning a lot of those provider numbers. They will be billing under their traditional number. And what I have

heard from Ms. Branham and the therapy TAC, we just need to follow-up with another letter to providers for clarification.

CHAIR PARTIN: Thank you. Physician services?

DR. NEEL: Physician TAC -- but I have a quick question.

Are we continuing to look at doing away with the Unbridled Spirit card? Everybody is getting two cards. The commissioner had mentioned before doing away with that card. Are we any closer to that?

It's really confusing for parents who come in with four kids and they've got 8 cards and they think they have a medical card with that and they don't because it's the Unbridled. It just has the Medicaid number on it.

COMMISSIONER LEE: I don't think there is any immediate plans to do away with that card but we will go back and discuss this issue.

DR. NEEL: Does it serve some purpose that we don't realize?

COMMISSIONER LEE: Well, there are some members, of course with the need for service billing, that only have the Medicaid card. But it

does have their Medicaid ID Number on it. Some of the MCOs have different ID Numbers. So this is something that we can explore.

DR. NEEL: Okay. Thank you.

CHAIR PARTIN: Podiatry? Primary care?

MS. BOWMAN: Good morning. Emily Bowman, Kentucky Primary Care Association. I wanted to let you know that the report that I submitted last week I've actually made some updates to. So I'll offer that just in case today. But just in case you're following along.

And I also submitted a worksheet or a spreadsheet along with that report just to provide you with some context and a visual as I talk about the reconciliation process.

I think it is helpful to see what providers are being asked to complete as part of that process. So that's in there for your information.

So the primary care TAC advisory committee met on Thursday, January 8. The majority of the TAC members were present along with DMS staff. And we also had representatives from each of the MCOs present. So that was very helpful.

The agenda items included the automated RAC payment process, which started July 1 of 2014.

And moving forward under this automated RAC process. We actually think that that is going fairly smoothly right now and is not the priority at this time. So we mainly talked about the second item on the report, which is the RAC payment reconciliation from November 1, 2011 through June 30, 2014.

And that, as part of that, we talked about the creation of a joint work group to address issues related to the reconciliation process.

And the fourth item has already been covered today so I won't go into that too much. But just talk a little bit about DMS's response to recommendations that have been accepted by the MAC.

So shortly after we reported to the MAC in November, the first phase of reconciliation complaints with dates of service from November 1, 2011 through June 30, 2014 began. And as part of this process, letters were sent to providers with claims data for that period. Actually there was a CD included that had all of the claims data on it.

For the majority of these clinics, their spreadsheets include hundreds of thousands of lines of data. So you can imagine claims for a

two and a half year period.

The letter required a 60 day turn around for the reconciliation process to be completed in order to determine whether money was owed to DMS or to the provider.

So as you can imagine these spreadsheets are daunting. And upon closer inspection, we are missing thousands and sometimes tens of thousands of lines of claims for medical, dental, and behavioral health visits. Because a spreadsheet does not include medication identifiers, practices are required to manually search for each claim which is extremely time intensive.

And this is an example. After starting the process, one large practice estimated that they would have to reallocate a number of their staff and have them work around the clock for that 60 day period in order to complete the process in time. You know, so for a large practice, this is a huge burden. But for many of the small practices, which the majority of them are, it is just simply impossible.

So when this was initially addressed with DMS, we were told that providers could request an extension, which many have done, and they have

been granted a 30 day extension. But in many cases, this isn't enough time to complete the process. An additional 30 days just doesn't provide the amount of time that they need to complete this.

So we raised the issue at the TAC meeting on January 8th and were told by DMS that they would consider granting additional extensions. We haven't gotten a final answer on exactly how that will work, but they are considering that.

There have also been two very positive developments this month that have the potential, at least, to greatly improve the reconciliation process. The first is in that each of the MCOs, as well as the DECAs, have agreed to work with our clinics to address missing data. One MCO in particular has agreed to share claim data directly with practices in order complete the missing fields.

And this has been tested with one practice now. It was very successful, but it did take about four weeks for that MCO to run the report and to get that information to the provider. So you can see that more than a 30 day extension is going to be needed in cases where there is

significant missing data.

The second positive development is that DMS agreed to meet with us this past Tuesday to review this spreadsheet and determine which elements on that spreadsheet, which you can see is fairly long, are essential for this process.

This would eliminate most of the data points that our members are currently having to search for and enter manually. So it would be a huge improvement for us. It was a very productive meeting and led to a better understanding of the reconciliation process from both sides. So we were very pleased with having that opportunity and want to commend DMS for, you know, participating in that meeting with us.

So while this does not solve the issue of missing claims data, it is a big step for us in getting the process to be more efficient. And we think it will greatly reduce the burden on the providers.

And as we reported I think the beginning of September, the TAC has been asking DMS to convene work group meetings with providers and MCOs all around the same table to proactively identify issues with the process and work to address them

from all sides.

While DMS has not agreed to initiate these meetings, they have since sent the invitation for a meeting that we set up with the MCOs to address the issue of missing data. And this meeting was scheduled for next week. So we should be able to report on the next MAC meeting on progress there.

Going forward, it is our understanding that there will be a final reconciliation process starting as soon as March. At this time we don't have much information about what that process will entail or require from our providers.

We expect there will continue to be challenges and issues that will be raised as a part of the process and will need to be addressed between providers, DMS, and the MCOs. And we hope that we can continue working together to address these and hopefully proactively before a lot of them come up.

So one final issue that we want to raise before the MAC is that I put in the report is just that issue of getting those recommendations. And I think that that's been addressed. So I won't go too far into that.

But we have had trouble getting, you know,

timely recommendations. And we think that the recommendation that you made today or the request that you made to DMS will help us prepare for future meetings.

Since a quorum wasn't present, I know that you have our recommendations from the November meeting. And there is really one that is still relevant that I just wanted to bring your attention to. And that is the recommendation about including additional identifiers on the EOBs, which would include MCO member ID, claim number, subscriber number, patient name, just as examples. And that would really help clinics to reconcile payments more efficiently.

In addition, we submit the following recommendations from our January 8 TAC meeting.

The first is in light of the fact that the reconciliation process for November 1, 2011 through June 30, 2014 includes a tremendous amount of pay claims data and requires a very manual process to complete the spreadsheet, we recommend that DMS adopt and disseminate the revised spreadsheet that we discussed with those essential data elements that we selected together on Tuesday.

And I included those elements in the report that I have here, but I don't think it is what you have. So I can read those to you. And I will make sure that you get a copy of my latest report through Barbara.

So these elements include the patient name, billing provider, NPI, that would be the clinic NPI, billing provider, Medicaid ID -- again, that's the clinic's Medicaid ID -- the reference provider Medicaid ID, the MCO name, the patient MCO ID. And this is the real sticking point for many of our providers because there is a Medicaid patient ID and an MCO patient ID and all providers don't really have the Medicaid ID. They have the MCO ID on their EOBs, and/or claims, but not the Medicaid patient ID.

I know that seems confusing. But that's one area where we really think we can make a difference if we use the MCO ID instead.

The date of service, procedure codes which are E and N codes, MCO payment map, MCO payment date and the primary care amount.

And additionally for the crossover claims, and that's where we talk about the Medicare crossover claims for dual eligibility, which is

another piece of the reconciliation process, the Medicare contract amount and the Medicare deductible amount. So we think these are the essential items.

DMS was agreeable to those, but we need a final approval for that. So we would like to recommend that they adopt those so that we can move ahead with revising the spreadsheet and making it a more obviated process.

And in light of the magnitude of this process, including the lack of adequate claims data provided by DMS, and given that we are dealing with the RAC payment and the Medicare dual/eligible issue, the primary care TAC recommends that DMS provide additional extensions beyond that initial 30 days to allow providers sufficient time to complete the process.

So while we would like to have it completed more quickly, and all of the providers are working on this very seriously, we feel it is much more important to accomplish the reconciliation process in a correct and equitable manner for all parties.

Our final recommendation concerns the process for responding to recommendations made by the TAC. And I don't know that I need to repeat that again,

but it is in the report. So that's all.

And if you have any questions, I would be happy to answer them.

CHAIR PARTIN: Thank you. And thank you for all of this work because those CD's were a little bit overwhelming.

MS. BOWMAN: They are daunting, yes. And I hope that you or any of the providers that are receiving our communications. And, if not, I can put you on our list.

CHAIR PARTIN: Would you? I'm not.

MS. BOWMAN: Yeah. I'll make sure that you're on there.

We have also been reaching out to the Kentucky Office of Rural Health to disseminate any of the information that we are putting out so they can participate in the process. But we haven't been able to get a full list of every licensed LAC and LPDC as far as email addresses. So we are continuing to work on that.

CHAIR PARTIN: Thank you very much.

Intellectual and developmental disabilities.

ARC OF KENTUCKY REP: I am with the Arc of Kentucky. And I am here today representing the ID TAC, Intellectual and developmental disabilities.

And glad to be here.

We met on last Friday, January 15. And our agenda, our agenda and our minutes from the last meeting, hopefully they are in your notebooks. I have sent those over. So I think by now you have those. But we met on the 15th. And our agenda included a presentation by Deloitte.

So -- and I was glad to hear some comments on that too already. But we were represented at the meeting. And with thanks very much to the departments that were there. It includes intellectual people with disabilities, family groups, our TAC, and it includes agencies and actually the Department of Medicaid was represented, the Department for Aging and Independent Living, The Department for Home Health. I think that's all. Sorry. I apologize if I left anybody out.

So one of the presentations that was made to our group, like I say, was by Deloitte. And I probably pretty much am going to have some of the same concerns that Sharon had with Kentucky Home Health.

We, that was, the whole presentation was really new to us. We didn't have that much

advance notice about the Medicaid waiver management application. So -- and so the Department for Medicaid Staff was there, which was able to -- which actually answered some of our questions. So that was very helpful.

But as the power point was brought up, they started on the power point presentation, it immediately started sending up red flags for some of us.

Because it is a crossover Medicaid waiver program. And it is electronic records. And it is on-line, it is streamlining. And one of our big concerns were that it was going to -- the training for case management for this program was going to begin right away in February. And a lot of people did not -- were not even aware, a lot of family members, individuals that use the waiver services were not even aware that this process was even going to be in existence.

And a lot of time sheets are done manually. So for this to be on-line, you know, may be a good process. I am not sure. It's just that we were not that -- we were not that familiar with it.

And with the go live date that they did say and as you have talked about it saying that it is

in April we just felt like that we should have had more information ahead of time.

And one of the big concerns has to do with the plan of care, with the plan of care with people that are on the waiver services. And where is that eligibility determination going to be made. And then with this going back to case management, which we work a lot with case managers for various agencies, there was just a lot of questions that we didn't get all of the answers to.

So, anyway, that was -- that was part of our program and for our meeting that day. And so we still had some questions on that. It was so new to us that we did not make a recommendation for it today though. But we still had lots of questions that we wanted to check with the Department of Medicaid on.

So we will follow up on that so that we have more dialogue with some of the questions that we did have. Because it was sort of our understanding, if I understood that correctly, this would start with a waiver program on cross waivers, but then would go to other state funded programs.

So I think this was my understanding from it. So, anyway, just to have a dialogue and to get more information.

One of the other discussions that we had, and I think that probably will be in our minutes as well, but one of the other discussions that we had during the meeting was as you had brought up too was the Pickle Amendment. And the Pickle Amendment was brought up as an issue which has been an issue for people with intellectual and developmental disabilities that are getting waiver services through the Michelle P, through the supports for community living. These people have been paying a co-pay.

So they have been paying a co-pay that they should have not been paying. So when that was discovered -- and it is called patient liability. So the, some people, some of the people that were receiving services were to be able to access those services through the SCO Program and through the Michelle P Program had to pay a co-pay to be able to access those services.

And then after many, many, many, many meetings, discussions and questions, and what have you, come to find out, some people that were being

charged that co-pay did not owe that co-pay and should have never been charged to receive the services.

And it has been kind of hard for them in a way because the people that wanted access to Michelle P services could not do so because the agency was saying, the agency that they were going to was saying for you to be able to access $20,000 of Michelle P, you have got a $270 a month co-pay that you have to pay.

And some people went ahead and paid that. Some people complained and said, no, I don't owe that. So there was some figuring that was done incorrectly.

And so as a result, people are now -- that money is due back to the actual people that actually had made those payments.

So what was discussed in our meeting is the slowness that is happening. So there are people that have been waiting for those payments to come back and they know the amounts that are supposed to come back to them. And I don't know where exactly the slowdown is, but people are not getting their money back.

And a lot of it has to do that it may affect

their benefits. But there is a spin down. So there is a spin down for that process. So it depends on the amount of money that is going to be coming back.

So in our group it has to do with the Pickle Amendment. But we discussed the slowness that that has happened because it has been determined that there is a group of people that were actually to be getting these funds back. But that is not happening. So it may be happening, but it is happening slowly. So that was two, number one and two.

And then the third thing that we talked about, among other things, but one of the things we talked about is we had submitted recommendations at the September MAC, to the September MAC. And we have not heard a response.

And our group decided that we wanted to bring those back to the MAC, to the MAC group today, because those are still really important issues that need to be relooked at and revisited.

And I do want to thank you, too, that we did get an email yesterday. We got an email yesterday afternoon that was in response to those recommendations. However, our TAC had already

discussed these again to bring back today. And I would like to just read over those if I could.

So -- and that recommendation that was made to the MAC was, is that our ID PAC it is very concerned about the 10,000 initial Michelle P. waiver slots that have been signed and then waiting list that has been initiated. And approximately there is 2900 individuals on the first come first serve basis. And, again, this was in September.

And while it is promising that additional funding has been allocated and the number of slots increased, it is clear that the demand is much greater than can be supplied with allocated funds.

We have expressed concerns that some slots have assigned individuals who do not meet the entry level of care standard, though the waiver was created in response to these adults for unnecessarily institutionalized, more than 70 percent are children. And while the children are being assessed with the map 5511. And an assessment tool is resulting in the inappropriate placement of many children in a waiver that was designed for adults.

And then the TAC, ID TAC recommendation was

that an appropriate two for evaluations for children and adults with that disability for the Michelle P waiver be finalized as soon as possible and not wait until the Michelle P waiver is actually revised.

And then we recommended that a special task force be made up of provider agencies, family members, children with IDD, and staff from Department for Behavioral Health and Intellectual Development and Disabilities and members of the House Bill 144 commission and the ID TAC. And this group would be tasked with the creation of a pediatric assessment tool to be implemented hopefully within 6 months.

And then additionally the group had recommended to specifically develop a separate waiver for children who do not the meet the institutional level of care, but still have a distinct need for services.

So the IDD TAC two, which is a really big issue, is the supports for community living program, the waiver program has participant directed services, the PDS. That is part of that waiver.

There are new employment requirements that

are imposed for those who actually receive personal care. Those costs include screening, background checks, CPR, and completion of numerous modules provided through the college of direct supports that is provided through the Department of Health and Behavioral Health and Intellectual and Developmental Disabilities.

The cost per individual wishing to participate direct in the services, the cost for them to do those requirements, for an employee to be hired is $372 estimate per employee. Many people don't have that. So it is an undue burden for people. And there is a high turnover rate.

So many people that are accessing services don't have $372 to pay per employee. So it is a big concern to us that that's a burden that puts people at risk to be able to live in the community.

The other recommendation was, well, to establish a mechanism to assist individuals to choose the PDS services with costs associated with an employee member requirement.

And then in addition to that, because of the federal mandates, because of the final rule, the waivers were -- and the waivers being rewritten,

we want to assure that similar unfunded mandates are not included in the revised Michelle P waiver or other waivers as participant directed services ultimately will be flowing across all of the waivers.

So -- and then I do have like a little breakdown of concerns if you would like a copy of that. We just feel like that the burden of expenses for pre-employment costs for people to access community service is still a really big issue. And, again, we did get a response and we got that yesterday afternoon. Our group has not had a chance to look at those. So thank you very much for the response. But we still have those issues.

So any questions?

CHAIR PARTIN: No. Thank you very much.

So we have the TAC reports.

DR. RILEY: I've got a question for program integrity, I believe.

We've gotten a letter that the requirement for the special EPSDT number is going away. However, at my office, we have still gotten ADO's for those numbers and follow-up phonecall or a follow-up letter if they haven't been received.

So is there -- do those ADO's still need to be completed right up to the time that the number goes away?

MS. GATEWOOD: What I would recommend is, what I have told providers is that you don't need the number any more, then our recommendation would be let the ADO expire. Or you can just send us a letter to say that you want to terminate the number, especially if there is a gap in between.

But the purpose of the EPSDT letter is to tell providers you have -- for those who already have a number and a different provider type as a dentist would, you no longer have to have the EPSDT. You should be serving -- provide those services under your other provider type. And when you need to provide services that are in excess of the state plan, you have to get a prior-authorization anyway.

So the need for the EPSDT number has gone away. So when it comes to an annual disclosure of ownership, if, you know, if you are not going to use the EPSDT number any longer, you could let the ADO expire and you would get automatically terminated.

MS. BRANHAM: Two ways. Or send a letter?

MS. GATEWOOD: Yes. Or you could send a letter.

CHAIR PARTIN: So we have the TAC reports. And do we have a motion to approve the recommendations in this meeting and the last meeting?

MS. BRANHAM: I make a motion.

MR. WHALEY: I second.

CHAIR PARTIN: All in favor?

GROUP: Aye.

CHAIR PARTIN: Any opposed? So that's approved. And hopefully we will be receiving responses soon.

The next item on the agenda is a presentation by Passport. And while they are coming up I would just like to make a quick comment, because we don't always say positive things. And I would like to thank Deputy Commissioner Wise for helping out a fellow practitioner. So thank you very much for your help. It has made a world of difference for her.

MS. SPENCER: Good morning again. Chrissy Spencer from Passport Health Plan. Joining me today is our CEO Mark Carter.

Prior to joining Passport, Mark held

executive positions at Saint Mary's Hospital and also spent 20 years as a leader in the Kentucky Health Care Facility Practice where he worked with many of the health issues throughout the state and all aspects of health management, finance and payment systems.

Mark has been the CEO of Passport since 2011. He is an active member of the community. He served on the executive leadership team for the American Heart Association and the March of Dimes. And was recently appointed to be the 2015 Chairman for the March of Dimes, March for Babies.

Mark serves on the Board of Advisory for the University of Kentucky Masters of Health Program and the Board of Directors for HealthCare Excel and the Foundation for Healthy Kentucky.

Mark is a Kentucky native and a graduate of UK. He resides in Louisville with his wife of 35 years. They have 3 children.

In your binders at the very last tab, I think it is the very last item on there, you will find a power point document that we will use as our basis of the discussion today.

We thought you would be interested in Passport's history, philosophy and structure, a

description of the programs we have in place to improve the lives of our members.

MR. CARTER: Thank you, Chrissy. I didn't know we were going to exactly do that this way. But as I was listening to the reports that were given earlier I was reflecting. Probably the way I got involved with health care was when I got out of the University of Kentucky in June of 1980, I joined Appalachian Regional Health Care as a staff accountant. And then it was known as Appalachian Regional Hospitals.

And that's really where the beginnings of my involvement with the Medicaid Program began. Most of my career, until the last four years or so, was spent primarily working with the provider community of concentration with hospitals. But also over those years, I worked with nursing homes and physicians and physician groups and some health insurers.

So -- but, anyway, reflecting on, you know, 30 plus years in the industry, I guess I have been working in Medicaid longer than the program existed when I first got out of school.

So my purpose today is to talk to you about Passport. And I intend to try to give you a

flavor of the organization from the perspective that you would get from a member of our board of directors. So that is sort of what I will try to bring to you today.

Before I move into it, I do want to thank you all for your service on the MAC. I think it is -- it would be notable and laudable in any event. But given the relative infancy of the Medicaid Managed Care Program in Kentucky is, by its nature, it is going to have issues that have to be dealt with. And I think your service on the MAC at this time with the kind of issues and complexity that you face is a credit to each of you.

So now that I have buttered you up, I will drop down to my comments.

The power point is in front of you. And I thought I would start out on Page 2, which is the value in the time power point or the correct page that you see there. I would just like to emphasize this and hopefully draw it out as I present some of Passport's results.

Passport's been in operation in Kentucky for 17 years. It was actually the product of a policy initiative that came out of the then Cabinet for

Health Services and the Department for Medicaid Services. And the concept and the idea behind it was to essentially engage a group of providers to manage the Medicare/Medicaid Program in a 16 county region, in this case Region 3.

And so the thing that you can look at Passport and gain some confidence in is that over time, managed care really can deliver value to Kentuckians, in particular in terms of improved outcomes, screenings, quality -- I think you are already seeing that in the other regions of the state with the reports that the department is furnishing you.

But Passport has a 17 year history that you can see over a period of time what the gains have been as well as financially.

So that's the purpose for that slide. It is something that we use to try to describe the overall strategy behind managed care.

Passport -- if you will flip to the next page with me -- Passport, as I mentioned, operated in Region 3, which is Jefferson County and the 15 surrounding counties. And just expanded into the rest of the state beginning in January of last year.

Just a little background about Passport and some of the things that I think is important to know is the plan was started by five safety net providers in Louisville, Kentucky. So those five providers at the time were the University of Louisville Physicians or the faculty and practice at the University of Louisville, the Louisville Primary Care Association, which included Park DuValle Community Health Center, Family Health Centers in Portland, as well as the University of Louisville Primary Care Center and the Metro Health Department.

Those two were sort of the driving forces behind the creation of Passport. In addition, the three downtown Louisville hospitals at the time, Norton Health Care, Jewish Hospital and the University Hospital were also part of that consortium.

In order to bring the plan into being, there was the belief that the engagement of providers had to be broader than just that downtown Louisville Medical Center. And so there was another organization created that I'll talk about in a few minutes called the partnership council that essentially brought together a group of

providers and advocates from across the 16 county region that became part of the Passport governance.

So the difference about Passport is we basically operate in one state, Kentucky. We don't have multi-state operations. And because of the nature of it likely never will. We are nonprofit. So it is a 501c3. We technically don't have owners. But those five entities I mentioned are essentially the nonprofit sponsors of Passport.

We have no ability to distribute funds outside of the Passport entity. Any funds that we generate from operating the program we have to find ways to reinvest those funds into the programs and services and access.

And, as I mentioned, we are provider sponsored. We do have one office currently, but that will soon change. Our primary office is in Southern Jefferson County near I-65, near Brooks and Kentucky. I say we are in the Greater Hillview area. If you are familiar with Bullitt County, you know what I am talking about. But that's where our office is.

But we will be opening an office in

Prestonsburg, Kentucky which should be opening in the next few weeks.

And that was an example of the kinds of things that Passport can do to invest in the community. Because we did that in sort of a collaboration with Shaping Our Appalachian Region initiative or SOAR. And Congressman Rogers and a Govern Beshear were very helpful in that effort.

If you will flip with me to Page 4, I do want to spend a few minutes here because I think this is important to understand about Passport.

We have sort of a dual governance structure. So as you look at this page on the left-hand side you will see the Passport Health Plan Board of Directors in the green boxes there. The Board of Directors of Passport consists of 15 people. There are five physicians on the board, there is a clinical psychologist, two nurses, and then representatives of the business community, among others.

So it is a 15 member board. And it is what you would expect in a board of directors in terms of its role. So it oversees budgeting and finance and corporate compliance. It has an audit committee, all of the kinds of things you would

see in any business enterprise is essentially covered by that board.

If you move your gaze over to the right side of that page, you will see the partnership council or organization. Now, the partnership council is actually a separately incorporated entity that has 30 plus members that are representative, number one, of a broad geography. So they come from across -- right now from the 16 counties former Region 3. And they would include physicians, nurses, representatives of the home health industry. It is chaired by Howard Bracco who is the former executive director of Seven County Services. There's psychologists, you know, optometrists, et cetera. So just about every sector is represented.

And the role of the partnership council is really to oversee the guts of the operation, so the things that really matter to the providers. So we do have an adequate network of providers in our regions or in the state now.

Do we, how do we establish our medical management or UM policies, those kinds of things. We have a -- it has long had a primary care work group that essentially oversaw the reimbursement

and the quality initiatives within the primary care medical home that we used in Region 3 for many years.

So they actually had the, and still have the, authority to sort of watch over those programs. And that would actually include any sub-contractor that we delegate it to; so our optometry group provider, et cetera.

So all of that is sort of covered in there. And that's where the authority, if you will, within the governance structure of Passport resides. So this is, you know, I always find it interesting that in the Affordable Care Act this concept of accountable care organizations. If you really look at Passport, you know, it was an accountable care organization before ACOs were cool. This is -- it is a group of providers charged with overseeing the health of the population of, in this case, Kentuckians, in a 16 county area. I think that's what an ACO is.

So this is how we get the high degree of engagement from the providers that we have enjoyed in Region 3. Our challenge, frankly, is to make this a state-wide entity. So as we look forward, those are the kinds of things we are going to be

trying to address so that we can make our governance structure more reflective of the entire Commonwealth.

I will talk a little bit about some of our programs, although I won't spend a whole lot of time on this given the hour. But we have, as I mentioned, a number of established programs. On this slide there is a few mentioned. And our care connectors or rapid response team, which I will talk about in just a moment. And you will see some of our care management and disease management programs there.

We put the dates in parentheses so you can see the length of time we have had some of these programs. And I think that helps explain some of the results that we are able to report.

Just about any impact that you are going to have on health and outcomes, as you all know, as most of you are on commissions, you know, you just don't get those in months, you get them over periods of years. And I think that's what we can look forward to coming out of the Medicaid Program in the future.

But you can see the prenatal, neonatal programs have been in place since 2000. And it's

not surprising those were among the first programs. And one of the leaders in the formation of Passport happened to be a neonatologist.

You can sort of take your finger down the page. Asthma, we have a very well developed asthma program, diabetes, and so forth.

We spent a lot of time trying to connect our clinical folks, our nurses and other clinicians that work in these programs with the folks that work in the community with advocacy organizations to try to connect the dots with our programs and with other folks that are going to have impacts on our members so that patients in areas that go to social determinants of health.

If you will flip the page to the rapid response team page, I thought I would talk about this just a little bit. This is a relatively new program that we have in place. And what it essentially is intended to do is to initiate outgoing calls or contacts with members in trying to either identify problems in advance and quickly solve them. Or on the other side of that is when something arises this is the group, you know, where you need a rapid resolution, this is our group of folks that deal with those kind of

things. Each one of these slides has a little example of the kinds of things that we do.

From an overall standpoint, you can see that in 2014 we had almost 300,000 outgoing calls from this function and about almost 42,000 incoming calls. We have 14 staff in that area. We make referrals to other community resources, other agencies that can help the members if it is a particular issue, if it's not a medical issue or if it's a medical issue connected to another issue we do that.

And about 720 referrals from providers that came out of just that team, that team of people.

If you will flip the page to the next page or disease management programs. Again, we are, we have established programs, but we are continuing to try to find new opportunities to have an impact on health within our population of members.

We added two new programs over the last couple of years in obesity and cardiovascular. Cardiovascular reflects the change in nature of our membership so we expanded a couple. Historically our membership was largely women and children in the old Region 3 days. With the expanded coverage, we have a much more diverse

population and need for new management programs. So that is a quick summary of the disease management programs.

Our case management, and I will spend just a little bit of time here with a couple of programs I want to talk about. One is our ER navigators and ER coordinators or ER management program. This obviously has gotten a lot of the attention in the hospital space. And it is a real source of, I guess, inappropriate and costly care that if we could get redirected would benefit everyone, including the primary care providers, members, as well as the hospitals, quite frankly.

So our ER navigators are nurses that essentially are in the emergency rooms engaging face to face with our members or when they present in the emergency room essentially trying to educate them on other options in cases, where possible, trying to get them into more appropriate settings for the nonemergency kinds of things that they might have.

The ER coordinators are located remotely. They are not in the ERs. But they get daily reports on ER utilization. And then they do telephone outreach to members also trying to

educate a member or connect them to a primary care physician or provider and that sort of thing.

We do have data that suggests that or verifies that in situations where we have a navigator in an emergency room we have been able to decrease ER utilization by 8 percent. We do take -- our focus is on education, working not only with the member, but with providers to try to have an impact on emergency room utilization. And we think that that engagement can make a real difference and our data shows that it does.

The second thing we have is we've developed a program a couple or three years ago I guess that we call it our Embedded Case Management Program.

And, in this case, what we did is we looked at our data and where our members were. And this was primarily focused on Region 3. And we found that 75 percent of our members were essentially served in about 30 individual practices. And so what we did is for those high volume practices we put case managers actually in the practice either on consistent days so that they could interact not only with the, again, with our members, but with the patients and their physicians and nurse providers in the case.

Some of these -- some of the impacts we have had through that program is that we have been able to reduce in the very high no show rates. We have reduced ER utilization and really focused on the gaps in care; missed mammograms, for example, depression, recalls that come that we have good data to show that those programs are effective. They are labor intensive but they are very effective.

On the next slide, just a quick overview of our community engagement and wellness programs. This was one of the things that was very attractive to Passport for me when I came on board is that Passport had spent a significant amount of time really becoming engaged and intertwined in the community. And so not just in with the provider group, but with advocacy organizations, even in the behavioral health space when Passport didn't have a behavioral health benefit, that was still under Medicaid Services.

And so these community engagement activities, our objective there is to be a part of the fabric of the community. I think that's one of the reasons why we want to have our office in Southeastern Kentucky. If we are going to serve

members there, we want to be part of the community. And it is funny. I am an accountant. And if I look at the ROI on a remote office, you would never do it because there just isn't one. But if you look at ROI a little more expansively, the dollars and cents, there is one. And I think that's been demonstrated in Region 3.

Some of the examples here is we have a program called Healthy Hoops Kentucky. It is connected to our asthma disease program. What this is is an annual event where we basically, you know, what else in Kentucky is basketball. So we organized a program aimed at children that the objective of which is to get them screened for asthma.

So there is a number of family clinicians mostly from the Jefferson County area that gather at a local high school. I think they started at a Male High School. It was at Doss, a high school now in the southern part of Jefferson County.

The face of that program is Darrell Griffith. So for the UK fans, it is the face of the U of L Cardinals which Darrell is a fantastic champion for that program. He has been the sponsor of it. Darrell comes to our office before that Saturday

and signs about 350 T-shirts. He signs every one of them. It is really phenomenal. I think we have offered to have them printed with his signature on it, but he won't do that.

So he shows up with usually some of the current team and some players from Bellarmine, and the kids go through the screening for asthma. And then, you know, they have a basketball game in the afternoon.

That program has existed for a number of years. And we have good data around that. And it is funded, in part, by a foundation. And we have good data around that in terms of increased screenings. And really for a small group of kids, compared to the entire Commonwealth, it has a real impact.

These are the kinds of program that we would like to replicate in our organization as our organization matures.

We would like to think, on the next slide, we would like to think that our investment goes beyond what a traditional Medicaid plan, and I know you probably hear that. But we, you know, I think because of the nature of the plan and the fact that most of us are Kentuckians who have

lived and worked in Kentucky for years, and, in particular, in the health space, I think we have, between our staff and our board, a very good understanding of some of the challenges within our population in terms of the things that drive their health status.

So that goes beyond just what we, you know, would define as health care. So, you know, education levels, job opportunities, those kinds of things.

But here, you know, I just wanted to emphasize that over time Passport has had about 94 cents out of every dollar that Passport gets in its contract with DMS goes out in the form of payments to providers. It is down a couple of pennies in the last year or so. It is closer to 92. But that's the level of spending.

So while our administrative cost is higher than what existed in the Department for Medicaid Services before managed care, you know, it is relatively low in comparison to what you would see in a typical insurance company.

We have 400 employees in Kentucky, most of whom are housed in an office in Louisville. But about 40 or 50 or so, something in that range, are

living in other areas of Kentucky working out of their home, some of which will be working out of that Prestonsburg office in a few weeks.

We have long believed, and I continue to believe, that connection to primary care between the health plans, that connection has to be very strong. It is the key to really making improvements in our populations. And we have long invested in that.

Passport, I mentioned the primary care work group that existed underneath the partnership council structure on a previous slide, Passport utilized a capitation payment essentially. So if you are a primary care practice, what Passport would do is we would pay the physician a per member per month for the Passport members that were assigned to their panel. And that capitation payment was constructed to sort of replicate a fee for service that had been historically. And it was a second layer of payment, called our Provider Recognition Program, which was essentially an incentive layer. It was material. So, you know, the last year that we had the exclusive from Region 3 it was about $5 million.

And the way that operated was this primary

care work group, along with the clinical folks at Passport, would develop the objectives for that year. So if you wanted to increase EPSDT screening, then, you know, there would be financial incentives associated with that that the primary care practice could earn.

And, you know, when you align the motivation with the money, it is amazing what will happen. And so, you know, over, since 2006 I think we paid over $46 million out through various incentive programs. In the last year alone, we paid out $5.6 million to primary care providers.

We are paying nurse practicers and physician assistants at 100 percent of the Medicaid fee schedule so we don't use a reduced payment there.

And as -- we think that the -- our decision to extend the enhanced payment through 2015 will be an investment of about $7 million.

I think, like the other plans here, we do want to get to a more advanced reimbursement program that tries to line up the quality and outcome objectives with payment over time. We viewed the extension of the enhanced payment as a bridge to get there.

Our intent would be to do that as long as it

is necessary. But we would like to get a more advanced model. And we are working on that.

I guess the final thing I would say that goes beyond a traditional plan is we have had in place for a number of years a grants program. Part of that grants program was an initiative called the IHOP Program. And it is not about pancakes. It actually stands for Improved Health Outcomes Program. And that is a -- sort of a program that invites proposals from providers to test innovative ideas in the hopes that some of those innovative ideas would work and it will be transferred into broad practice.

And we have a number of examples of where we -- where that has been successful. Probably the most visible one is the Kangaroo Cares Program, which was a $50,000 IHOP grant that was given to some physicians at the University Hospital, probably 10 years ago I would say, that was essentially developing a program to encourage mothers to breastfeed.

And that program now is in, I believe, every single hospital in Kentucky that provides -- that delivers babies. So I don't think that's an exaggeration. I think it is in every hospital.

So that's an example of a tremendous success that came out of that program. And I don't have to describe the benefits of that for babies and folks having healthy babies.

There is a number of others that I could talk about, but given the time I won't. I will say this, you know. When you fund grants, most of the time they fail. You know, good ideas, but the ability to replicate them, you just can't do it for whatever reason. And we view that, though, as part of the process. And I think that's one advantage of being affiliated with the university is, you know, you have to try things. And some things are going to work.

But, you know, it's like drilling oil wells I think. Most of them don't.

So -- but we are committed to that program and it will be in place going forward.

Then the last slide, and I will close and take any questions that you might have, but just looking ahead, you know, I am sometimes a little self-conscious with our competitors and peers. And sometimes maybe we come off as, you know, trying to say we're better than everybody and that sort of thing and that's certainly not the case.

Our orientation is that we have to constantly improve. And while we have a history of success, we've got -- we've got our own challenges as an organization. We are local. That has advantages in terms of flexibility and ability to do things. But it also puts restrictions on us because we don't have a large pool of capital to draw on and to invest in these programs. We have to be very prudent financially.

But we know that we need, as we move outside of Region 3, that we need programs that are going to be responsive to the individual communities as we have begun to work with them.

While we have an affinity to primary care, we are just getting started really working with the Kentucky Primary Care Association. We are learning about different locales and practices and so forth. So we are committed to continually improving the organization.

We do believe, and I believe very strongly, that in that integration between the provider and the financing of health care -- and this isn't new in Kentucky or it isn't new in the nation -- but it is kind of a novel concept in Kentucky. But as we look forward, trying to find ways to really

engage between the plan and physicians and other providers, it is top of the line for us.

And, finally, I will say something about behavioral health and orientation toward behavioral health. And there are folks in the room that are aware of this. But Passport, probably 10 years ago, aggressively sought the opportunity to have the behavioral health component integrated into the managed care plan.

And it was a desire of both Passport and the Department for Medicaid Services as well as the leadership within Department of Mental Health within the state. So we have long believed that if we could get the mental health benefit and the physical health benefit combined into a single program there would be real opportunities to improve services to folks with behavioral disorders, substance abuse, et cetera.

But also by doing that, it would have a very significant impact on physical health and on the overall cost of the program.

So we are aggressively working with our behavioral health partners in Region 3 to try to find new ways to make that happen. And we don't have the answer yet. But it is something that as

an organization we're very committed to do.

I mentioned before we have Dr. Bracco as the chair of the Partnership Council. He also serves on the board of Passport. And Allan Tasman, the Chairman of the Department of Psychiatry, also serves on the board of Passport.

So that's one thing where I'm not in a position yet to talk about some of the things that we are going to try do here. But it is something we are very committed to at Passport.

So with that, I guess I'll stop and see if you have any questions for me. And most of them I probably won't be able to answer. But that's --

CHAIR PARTIN: Thank you. Any questions?

MS. ROARK: I have some questions.

I'm from Prestonsburg. I'm happy to see that you are opening an office there. Are you hiring some people for that job location?

MR. CARTER: Yes. We just -- we actually just hired a manager for that location. And he was in Louisville being oriented into Passport. Spent about a day with all of my new management and just getting them oriented in the Passport vision and values the way we want to operate as well as they had to learn to fill out time reports

and that sort of thing.

But we have hired a manager. Our plan is to initially have 15 people located in that office. It is in a strip shopping center there right in Prestonsburg. And over time it is, you know, the objective is to grow that into a significant presence that is connected to how quickly we are able to grow in Region 8.

MS. ROARK: From me being from there -- but I live in Nicholasville now. But there is a shortage of jobs and substance abuse, people struggling. And I am hoping and happy to hear how that works out and grows. And if someone is looking for a job and if they have any openings, would they go to your website?

MR. CARTER: You can go to the website. There are job postings on there. And that's where resumes can be submitted. Eventually we will have the office open and there will be folks there and folks can explore opportunities.

MS. SPENCER: We are also working through the economic development department there. We have all of our listings.

MS. ROARK: Thank you.

MS. BRANHAM: I would just like to say, I am

from Prestonsburg and welcome you to the area.

DR. WATKINS: I had a question, too. I did not hear any response by Passport on the comprehensive eye exam and the provider for a year. That was still hopefully on their part and we are waiting for an answer on the response to that.

MS. SPENCER: Can I follow up with you after the hearing? I think we are waiting for a specific answer. We don't think we have that data. We do have some more specific examples.

DR. WATKINS: Okay.

CHAIR PARTIN: Anything else? Thank you. Thank you for the presentation.

Okay. Under new business we have two items. And the one item, Coventry pharmacy help was requested by our pharmacy MAC member. He is not here. So we will delay that question until the next meeting.

The other question has do with pre-authorization that's required when a provider goes into a group home for visits. And what I am told is that if a provider goes to a group home to do med reviews or med checks or see people who are in that residential home for acute problems that

pre-authorization is required.

And so my question would be, why is that and how can you anticipate that you are going to -- who you are going to see when you might be seeing acute problems at a group home?

COMMISSIONER LEE: I'm sorry. I don't have information and an answer to that. But I can take it back and research it. Is this a fee for services or a managed care issue or just in general?

CHAIR PARTIN: Just in general.

Pre-authorizations for all of the MCOs is required. And this is with behavioral health with all of the MCOs. And the codes that they were talking to me about were 90791 or 90792. Let's see. 90833, 90837, 90839. I don't have another code.

And then I was told that in the initial contract, if you included nursing home, then you could use the 99201, 99203 basic AM codes for that visit. But they weren't sure about that.

COMMISSIONER LEE: So the managed care companies can establish prior-authorization. And I guess I can let each one speak to that. If they are not prepared to speak to it today, maybe they

could follow up at the next MAC.

CHAIR PARTIN: That would be fine. Follow-up at the next meeting. So basically it is about requiring pre-authorization visits to a group home.

Anybody have any other business they would like to bring forward?

MS. EPPERSON: Madam Chair, if I may. I would just like to comment real quick on the recommendations.

One of the barriers the department continues to experience is receiving all recommendations that's presented to the MAC in writing to us so that we can draft a response and send it out.

So I know that today home health, I haven't received your recommendation. So if you could get those to me or to Beth. And you can get those to me. We have to have them in writing before we can respond. And that's been one of the delays in us actually responding to some of these. We haven't been getting them.

The TACS have presented them to the MAC and then they don't get to us.

CHAIR PARTIN: So also for those of you TAC

members who are in the audience, that would be important to get those written recommendations to us so that we can get a response for you.

MS. UNDERWOOD: I am MaryLee Underwood with the Commonwealth Council on Developmental Disabilities. And just wanted to bring an important issue to the attention of this group for you guys to monitor over the next period of years really.

Last spring the center, the Federal Center on Medicaid and Medicare Services, issued new regulations for home and community based services. Those are going to be triggering changes in all of Kentucky's waiver programs. That process has just begun. And the state has five years to come into compliance with those new regulations.

A transition plan was released. And public comment has already been taken on that transition plan and the final transition plan submitted to the Federal Center for Medicare and Medicare Services. It is going to be an incredibly important issue that's going to change all of the waivers and how services are provided for individuals with developmental disabilities as well as those with acquired brain injuries.

Anyone who receives home and community based services, which would include many elderly patients of yours.

So I just want to highlight that as a critically important issue that we will be watching, along with other members of the House Bill 144 Commission. We are working to sponsor community forums, which someone mentioned related to this in February.

There are four happening throughout the state. And then public testimony will also be taken at the next House Bill 144 Commission Meeting.

But I don't think that the importance of this issue could be overstated because it is going to be dramatic changes. And lots of your patients and providers are going to be having lots of questions coming up.

Overall, the intent is to ensure that people can get the services that they need in their communities. And in comparison to other states, Kentucky seems to be doing perfectly well. Our national alliance reviewed our transition plan. And compared to other states said that our transition plan looked good. They suggested more

input from -- more opportunities for input from individuals and family members who would be impacted as well as a few other suggestions that have been passed on.

So this isn't a criticism in any way of our Medicaid folks. But just to say that this issue is going to be important. And I hope that you will watch it closely and keep it on your radar.

CHAIR PARTIN: Could you send us something in writing about what you just said?

COMMISSIONER LEE: I appreciate your comments, Ms. Underwood. And thank you.

At the next MAC meeting if you would like we could have members of Medicaid present on the new HCBS rules. If you would like to put that on the agenda for presentation so you could become familiar with the process of that.

CHAIR PARTIN: That will be.

COMMISSIONER LEE: HCBS as the home and community based waiver services. There are some new rules for those waivers. And we would be more than happy to make a presentation at the next MAC.

CHAIR PARTIN: Great. Thank you.

Is there any other business? That's it?

Then I make a motion to adjourn.

DR. RILEY: So moved.

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MEETING ADJOURNED

* * *

CERTIFICATE

STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Georgene R. Scrivner, a notary public in and for the state and county aforesaid, do hereby certify that the above and foregoing is a true and complete transcript of the ADVISORY COUNCIL FOR MEDICAL ASSISTANCE, taken at the time and place and for the purposes set out in the caption hereof; that said meeting was taken down by me in stenotype and afterwards transcribed under my direction; that the appearances were as set out in the caption hereof; and that no request was made that the transcript be submitted for reading and signature.

Given under my hand as notary public aforesaid, this the 24th day of February, 2015.

_____
Georgene R. Scrivner
Notary Public - ID 445375
State of Kentucky at Large
CCR#20042109

My Commission Expires: 7/15/2015